

Prescription Fax Form

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Patient:

Please fill out step 1 and bring this form to your doctor. This prescription request is only authorized when faxed from the physician's office. Please copy this form for your other medication(s).

Physician:

Please fully complete steps 2 to 5 below to help ensure timely processing of your patient's prescription.

Questions? Call Customer Service at 1 888 327-9791.

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**Step 1. Please complete missing information below.****Member #****Member Name (card holder):**

(First)

(Last)

Shipping
Address:

City

State

Zip Code

**Step 2. Complete
Patient Information:****Patient DOB:**.....*Please check all that apply:***Allergies:**

- None Sulfa Penicillin
 Aspirin Codeine Iodine

Medical Conditions:

- Heart Attack/Angina Heart Failure
 Asthma High B.P.
 Ulcer Glaucoma

Other**Step 3. Please Write or Attach Prescription Below.****Prescription watermark security forms will obscure legibility when faxed.****Prescriber's Name
And
Address Required****Patient Name:****Address:****Issue Date:** / /**Rx****Step 4. Prescriber
Information:****Prescriber Fax No.****Print Prescriber's Name****Substitution Permissible - Prescriber Signature**
(We cannot accept Signature Stamps)**Step 5. Sign and Fax Back to:****1 800-837-0959****Dispense as Written - Prescriber Signature**
(We cannot accept Signature Stamps)

Please do not fax with a cover sheet. We do not accept CII prescriptions via fax. Fax forms will only be accepted if faxed directly from a prescriber's office. Most patients can receive a 90-day supply plus refills up to 1 year where appropriate.



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